IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 30, 2010

Michael Day, Administrator
Independent Living Services-- Freedom
PO Box 6395
Boise, Idaho 83711

RE: Independent Living Services-- Freedom, Provider #13G031

Dear Mr. Day:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Independent Living Services Freedom, on March 23, 2010.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey. Also, enclosed is a similar form stating that no State licensure deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208) 334-6626.

Sincerely,

ERIC MUNDELL
Health Facility Surveyor
Facility Fire Safety and Construction Program

EM/lj

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G031	A. BUILDING 02 B. WING _____	03/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENT LIVING SERVICES - FREEDOM	11577 W. FREEDOM BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V (000) building built in 1998. The facility is protected by an automatic fire sprinkler system in habitable spaces. There is a fire alarm/smoke detection system installed. Currently the building is licensed for 4 beds. The facility was found to be in substantial compliance with applicable fire/life safety requirements set forth in the Life Safety Code, 2000 edition, Chapter 33, Existing Residential Board and Care Occupancy, Impractical Evacuation Capability and 42 CFR 483.470. The annual fire/life safety survey was conducted by: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 000	16.03.11 Inital Comments The facility is a single story, type V (000) building built in 1998. The facility is protected by an automatic fire sprinkler system in habitable spaces. There is a fire alarm/smoke detection system installed. Currently the building is licensed for 4 beds. The facility was found to be in substantial compliance with applicable fire/life safety requirements set forth in the Life Safety Code, 2000 edition, Chapter 33, Existing Residential Board and Care Occupancy, Impractical Evacuation Capability and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF-MR). The annual fire/life safety survey was conducted by: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	M 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE